Mail

Correcting the record

To the Editor

After the publication of our research paper in 1997,[1] we became aware of a compromise in the quality of part of the data set collected by a study interviewer. A formal review confirmed that the interviewer had created some records that were duplicated or inconsistent. This constituted clear misconduct in 75 of 1,710 interviews. Additional interviews had fragmentary documentation, which could have compromised at least part of 449 interviews.

The original study examined the relationship between subspecialty follow-up for asthma and measures of medical care provision, utilization of health services, and functional status. We analyzed survey responses at a baseline interview and at follow-up interview approximately 18 months later. Subjects themselves reported the specialty of the physician whom they considered the main provider of their asthma care. Adjusting for demographics and asthma severity, allergists were more likely than pulmonologists to provide a peak flow meter for patients or to administer allergy desensitization injections. They were less likely to prescribe high-dose, inhaled corticosteroid therapy or to administer pneumococcal vaccination. After adjusting for the same covariates, no subspecialty association emerged in relation to emergency department visits or hospitalization for asthma. Those who reported that they had switched specialty care providers had statistically worse quality of life and worse physical function as measured by the SF-36.

We have reanalyzed the data, excluding the compromised and potentially compromised records. We determined that 21 of 539 subjects (4%) were out of the original age range for the study. For an additional 135 subjects (25%), re-interview data had major inconsistencies or where telephone billing records did not clearly provide secondary validation of interviews. We, therefore, excluded 156 subjects (29%) in this initial reanalysis.

We then carried out a second, more restricted reanalysis to remove interviews that were too short. We excluded 65 subjects (12%) whose baseline interviews were less than 30 minutes because these interviews could have represented fragmentary records if they were performed rapidly. We used 20 minutes, based on telephone billing records, as a minimum completed time for the follow-up interviews. We excluded 71 subjects (13%) whose follow-up interviews had originally been 15 to 20 minutes.

The final reanalysis was, therefore, limited to 247 subjects. Allergists were still more likely to supply their patients with peak flow rate meters and were less likely to prescribe high-dose, inhaled corticosteroid therapy. After adjusting for covariates, there was still no association between subspecialty type and rate of hospitalization.

In the original study, patients who switched specialists had a worse quality of life, but this difference was not statistically significant in the re-analysis. The association between switching specialist and experiencing worse physical function was statistically stronger in the reanalysis. Detailed statistical information about the reanalysis is available at: http://medicine.ucsf.edu/divisions/oem/asthma_panel/.

Although we found no substantial impact on the principal major findings and interpretation of the previously published paper, I and my coauthors believe that the scientific record should be corrected.

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References

1 Blanc PD, Katz PP, Henke J, et al. Pulmonary and allergy subspecialty care in adults with asthma: treatment, use of services, and health outcomes. *West J Med* 1997;167:398-407.